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Gambling risks: Exploring social work practitioners' experiences of clients presenting with risks of gambling-related harm

Abstract

Gambling is increasingly seen as a public health rather than an individual problem. Opportunities to gamble have grown in England in the last decade since the liberalisation of the gambling industry. This exploratory study investigated the experiences of 21 practitioners about gambling among adults with social care needs. Practitioners were interviewed about their understanding of the risks to their clients arising from their own or others' gambling participation, how they support clients in such circumstances and their views of how practice could be developed to better support clients experiencing gambling-related harm. Analysis revealed themes covering: 1) concerns about the pervasiveness and appeal of gambling; 2) lack of knowledge of the complexities surrounding gambling and gambling-related harm; 3) uncertainties about how to support adults with care and support needs at risk of gambling-related harm; 4) desire for professional development activities. This study highlights practitioners' concern about gambling-related harm and their wish for guidance about good practice in this area.

Gambling risks: Exploring social work practitioners' experiences of clients presenting with risks of gambling-related harm

Background

The gambling industry in the United Kingdom (UK) was substantially liberalised with the implementation of the Gambling Act 2005. Gambling is now more accessible in local communities and available online. Such changes have led to debates about the potential impact of gambling on individuals, communities and society (e.g. HL Deb 12 January 2017, vol 777). While there has been some discussion about the steps which should be taken to protect 'vulnerable' people from gambling-related harm (GRH) (e.g. MacInnes, 2017), so far direct practice experience has not been widely reported.

Gambling is a common leisure activity in the UK. In 2017, 45 percent of the population gambled in the past four weeks (Gambling Commission, 2018). However, people who gamble may experience GRH, defined as 'the adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society' (Wardle, Reith, Best, McDaid & Platt, 2018). Types of GRH include debt, relationship problems, detriments to health, and reduced performance at work or study (ibid).

The term 'vulnerable adults' is used in UK gambling regulation, as 'people who gamble more than they want to, people who may not be able to make informed or balanced decisions about gambling due to, for example, mental health problems, a learning disability or substance misuse relating to alcohol or drugs' (Gambling Commission, 2016: 5.17). Furthermore the UK gambling regulator aims to 'protect children and other vulnerable persons from being harmed or exploited by gambling' (ibid: 1.20).

Currently over 400,000 people in the UK are classified as problem gamblers (Conolly et al., 2017) defined as 'gambling to a degree that compromises, disrupts or damages family, personal or recreational pursuits' (ibid:1). Approximately 1.5 million people are at-risk gamblers (Davies, 2017), defined as people who are at risk of problems related to their gambling behaviour but who are not classified as problem gamblers (Conolly et al., 2017:1). Calls for problem gambling to be viewed as a public health concern have been made by the UK's gambling regulator (Miller, 2017), medical leaders (The Lancet, 2017), Public Health England (Brine, 2018) and by senior advisors to governments (Welsh Government, 2018).

Encouragement for social workers to address GRH has come from Rogers (2013), the Responsible Gambling Strategy Board (RGSB) in England (RGSB, 2016), and GambleAware (2017), the industry-

funded gambling support charity. Rogers (2013) argued that gambling problems should be on the 'radar' of social work in England because the risk factors associated with gambling also relate to the reasons for contacting social services. The RGSB has recommended that local authorities consider gambling when assessing risks to the wellbeing of their communities (RGSB, 2016). GambleAware (2017) has developed a Brief Intervention Guide to address a perceived lack of guidance for people working in social and criminal justice settings (including some social workers).

A recent scoping review revealed limited evidence about social work practice in relation to GRH (Manthorpe, Norrie and Bramley, 2017). This review revealed three themes – the near 'invisible' social worker in gambling research; the 'invisibility' of gambling in most professional qualifying social work programmes internationally; and the near 'invisibility' of the impact of gambling on social work clients (ibid). The English Local Government Association (2013) observed that problem gambling is rarely put forward by individuals making contact with social workers as their presenting need, though the basis for this observation is unclear. However, Manthorpe et al. (2017) noted that as social workers are the largest professional workforce in local authorities, they may have a role to play in addressing GRH, combining work with individuals and families with partnership and collaborative working with local communities. Some literature further suggests that the urge to gamble may lead some people to abuse, neglect and/or steal from vulnerable adults, but the extent of this is unclear (ibid).

Such lack of evidence about frontline practice in England with adults at risk of GRH prompted this exploratory study. This paucity is mirrored internationally, for, while responsibilities for GRH may vary, a recent study in Finland found social services' directors were unable to quantify the extent of their agencies' work in respect of GRH (Heiskanen and Egerer, 2018). The focus of this paper is on practice with adults with needs for care and support arising from disability, age, long-term health conditions or other support needs. In this paper, while a range of terms were used by practitioners to refer to such individuals (e.g. client, resident, service user); the term client is used for consistency.

Aim

This study aimed to explore practitioners' experiences and perceptions of how GRH affects their clients and how they might support clients experiencing or at risk of GRH.

Method

Sample and recruitment

We devised a sampling framework to access a broad range of practitioners and sought volunteer participants from different services and organisations. Details of the study were disseminated via social media, circulated to Safeguarding Adults Board managers in England, the Local Area Research and Intelligence Association membership, and in an article published in *Community Care* (an online social work magazine). Informed consent was obtained before interviews commenced.

Semi-structured telephone or face-to face interviews were conducted between May and December 2017. Twenty-one practitioners (11 female, 10 male) were interviewed comprising eight social workers, three senior social workers, two people representing gambling support services, two people working in safeguarding, two housing officers, one mental health outreach worker, an advocate, a local authority employee and a practitioner who worked in adult day care centres. Data collections ceased when no new themes were emerging.

Materials

Open-ended questions were employed to capture participants' experiences of working with adults who had experienced GRH, or people who had harmed or neglected vulnerable adults to fund their gambling participation. Participants were asked about current practice when encountering GRH, whether they felt equipped to deal with this area of practice and their knowledge of gambling industry initiatives designed to minimise GRH. Finally, they were asked about how best to support vulnerable clients who may experience GRH. Interviews were audio recorded, with consent, and transcribed.

Data analysis

Transcripts were inputted into NVivo7 to facilitate data analysis. Data were analysed using Thematic Analysis which provided flexibility so that experiences and meanings were examined across an entire dataset and common themes and differences were examined between participants. Thematic Analysis enables researchers to scrutinise data in detail through identifying, analysing and reporting themes (patterns) within data (Braun & Clarke, 2006). The five phases of Thematic Analysis were followed – 1) Familiarisation with the data (the researchers repeatedly read the transcripts); 2) Generating initial codes; 3) Searching for themes; 4) Reviewing themes; and 5) Defining and naming themes (ibid).

Ethical approval

This study was approved by King's College London (Ref: LRMR-16/17-3454). Care was taken to ensure discussion of illustrative cases was recorded and reported anonymously.

Findings

Four main themes were identified: 1) concerns about the pervasiveness and appeal of gambling; 2) lack of knowledge of the complexities surrounding gambling and GRH; 3) uncertainties about how to support clients experiencing GRH; 4) desire for professional development activities.

Concerns about the pervasiveness and appeal of gambling

Many interviewees articulated reasons why gambling participation seemed to appeal to many adults in contact with social work services. Practitioners commented that, for some of their clients, gambling environments are familiar environments, visiting them can become part of a daily routine, and they are places which facilitate social interaction:

'So it's their social network. They go in there, they're greeted, they know the people that are in there....they get their free tea and coffee, it's a nice warm environment...you can see why they go there and there's no questions asked... they've got the skills to be normalised within that environment' (Manager - Supported Living Accommodation)

Gambling was described as being very attractive to some clients. One participant illustrated its appeal to a client living with a personality disorder, for whom forming relationships with other people was very difficult. The client was described as visiting amusement arcades and high street betting shops in the evening so as to gamble alone and keep him 'safe' from the world:

'gambling...it's part of his life...it's one of the ways that he kind of isolates himself, he just goes off and has a relationship with a fruit machine or latterly a fixed-odds betting terminal' (Mental Health Outreach Worker)

This participant also remarked that gambling seemed to appeal to another client living with a learning disability because it was 'exciting'. However, the worker thought that this client did not fully understand the risks associated with playing fruit (slot) machines or recognise the potential impact of her spending on her health and wellbeing:

- 'she (client) was gambling on fruit machines ... she thought she could win money by gambling and thought it was a bit like the post office (savings bank) almost, you put some money in the fruit machine and it sort of dispenses money to you, she didn't really know whether she was winning or losing I don't think half the time, she just didn't understand, so she was kind of gambling for the thrill of it, she must of known whether she was winning or losing but she didn't kind of really recognise the damage that she was doing, she just thinks there's an endless supply of money and in some ways there is, she's never going to work so she just gets an endless supply of benefits' (Mental Health Outreach Worker)

Other practitioners commented that gambling advertisements on television seemed to hold great appeal to their clients. One practitioner thought that gambling was unrealistically portrayed:

'the adverts themselves all promote having such a good time...but then they wouldn't really say, if you wanna be in debt, have no money, become socially isolated and can't look after yourself, gamble' (Senior Social Worker 2)

Other practitioners commented on the appeal of mobile and online gambling, which may be increasingly undertaken by isolated older people:

'I think more and more, older people, especially with social isolation are, you know, you've got your phone, you can have a quick bet. Then we may find in the future that more and more people have got that mobile phone and use that as, as something to do when they are isolated' (Senior Social Worker 3).

Online and mobile gambling was thought to appeal to women as it is a form of gambling 'that nobody else can see' (Gambling Support Charity Employee 1). Another practitioner commented that online and mobile gambling appealed to clients because they could gamble if their mobility became impaired (Senior Social Worker 3).

Lack of knowledge of complexities surrounding gambling and GRH

All participants had some experience of supporting clients experiencing GRH, although they had generally encountered few cases.

‘We’ve only had one or two in the last two years...but my guess is it’s, well it’s, you know, it’s a bigger problem than that’ (Senior Social Worker 2).

‘We don’t come across those cases on a regular basis’ (Senior Social Worker 3).

Practitioners thought they encountered few cases because of the hidden nature of gambling participation and GRH. The lack of physical signs of problems which often accompany alcohol and/or drug misuse, together with scant discussion of gambling, often led to GRH remaining undetected:

‘I suppose in comparison to other areas, I think other areas tend to hit you earlier because the effects are more striking. So if somebody is misusing alcohol, you can tend to pick it up a bit quicker, same with substances. Gambling addiction, it might take longer or it might go below the surface and only comes to the fore when a major crisis happens’ (Practitioner - adult safeguarding).

‘It’s not something that was visible, it wasn’t something that was discussed; it wasn’t something that clients would talk about... I mean I did have a client with end-stage alcohol abuse, so alcohol felt more visible. The gambling just felt like it didn’t exist really’ (Social Worker 1).

Another practitioner agreed that it could be difficult to address GRH with clients:

‘it’s not until a relationship develops or you’ve met them often that they would tell you that they’ve got an addictive behaviour or you recognise that they have or you see signs, or bills aren’t being paid...it’s a bit like a secret that comes out later’ (Senior Social Worker 3).

There were other reports that third-parties (e.g. carers, friends, family) might raise concerns about the possibility of GRH if they felt that the social worker might be trusted:

‘carers have said, I’m really concerned because they’ve got no food, they’re not paying their bills... they are gambling, they are drinking ... can we intervene? (Senior Social Worker 2)

The lack of data about how many clients might be affected by GRH may also have contributed to this area of practice being under-developed:

'hard to say it's a priority because if we don't know how big it is, then you can't establish it, you can't prioritise it' (Social Worker 1)

Other pressing problems could explain why GRH was not high-profile:

- 'I don't think it is a priority for the local authority to be honest. We've got a lot of other things ... such as child sexual abuse, modern day slavery, which are much more on our agenda because ... we have more cases of that' (Social Worker 2)

However, several practitioners thought that there might be more cases of GRH in the future. One remarked:

'I can see it, it's becoming a priority because of the way it filters through to so many other problems, and how it does impact on the whole family and the whole structure' (Social Worker 4).

Despite some practitioners' lack of knowledge of gambling and GRH, most thought that GRH should be a public health issue, primarily because it could impact on individuals, families, children, society and the demand for public services including social work services:

'I do think it's a public health issue in the same way that smoking is...people can choose to do it, and alcohol, but it does actually impact on the individual and the country's resources' (Social Worker 2)

Other practitioners were unsure as to whether GRH was a public health issue but expressed concerns about its potential impact on resources:

'it can be...because I just feel like it can trigger off just so many other things, like mental health (problems), and drinking, and taking drugs' (Social Worker 4)

Despite the low number of cases encountered by participants, the impact of GRH for some clients was evident. Practitioners reported clients experiencing money problems, housing instability, relationship problems, detriments to their physical and mental health, feeling anxious, feeling regretful and selling their own and others' possessions to fund their gambling. Gambling participation was also thought to contribute to self-neglect and social isolation. The majority of clients discussed were receiving welfare benefit payments which they used in part to fund their gambling.

Clients could also experience GRH as a result of other people's gambling. Practitioners recalled incidences of some clients being subjected to physical abuse, financial abuse, exploitation, modern slavery and controlling behaviour by family members in order to obtain money to gamble. However many clients did not want to report such behaviour to the police but preferred to receive further support in helping to manage their money:

'the victim was very unwilling to pursue that line through the police, but he was willing to accept further support from adult social care' (Safeguarding Adults Manager)

Despite supporting clients experiencing GRH, practitioners themselves were largely uninformed about gambling and most did not have any or much first-hand personal experience of gambling:

'I haven't been to a casino before....'cause I'm not into gambling...I haven't been to any betting shop' (Social Worker 6)

Some practitioners had found the Making Safeguarding Personal (MSP) guidance useful when supporting clients experiencing GRH. The MSP approach is that safeguarding (protection of vulnerable adults from abuse) should be person-led and outcome-focussed so that people are involved in responding to risks of harm in ways that enhance involvement, choice, and control as well as improving quality of life, wellbeing and safety (Department of Health, 2016, para. 14.15). For example, one practitioner dealing with an alleged case of financial abuse explained that MSP guidance helped ensure her response was person-led and outcome-focussed:

'Somebody might have a close relationship with their brother, and that brother's been misusing that person's finances or encouraging that person to gamble. The person with the learning disability, if he or she has capacity, might say, I love my brother very much, I don't want the police involved, I'm happy for some family counselling, then you would do your best to accommodate the wishes of the person. And the guidance through that comes from MSP' (Practitioner - adult safeguarding)

Uncertainties about how to support clients experiencing GRH

The extent that practitioners felt equipped to manage incidences of GRH varied. Some practitioners wanted to be able to approach professionals who more regularly support gamblers to draw on their expertise:

‘I think we haven’t got a wealth of experience at the moment to draw on ... once we’ve got that kind of experience we’ll be able to support each other a bit more with it....we could do with some experts to call and pick the brains of’ (Senior Social Worker 1).

One practitioner was more confident about managing incidences of GRH:

‘Yes I think so. I think definitely within my organisation we are’ (Cluster Manager - Supported Living Accommodation).

Most were far less confident about their ability to manage such incidents:

‘what I felt was the kind of lack of resources, or possibly not knowing about resources, where to kind of go with it in terms of gambling because I hadn’t come across it ... I think we kind of muddled through it okay’ (Social Worker 5)

Most practitioners acknowledged that adults have the right to participate in gambling and make unwise decisions:

‘we aim to give the individuals, freedom of choice because that’s what it’s all about. It’s their lives it’s not our lives. We’re supporting them to live their lives the way they want to live.’ (Cluster Manager for Supported Living Accommodation)

However, many practitioners thought that it was easier to support clients who lacked the ability to make decisions about gambling because this could be established through mental capacity assessments and action then taken:

‘if someone lacks capacity to manage their finances or understand we would obviously have to look at what was in that person’s best interests, but if someone had capacity, we could only encourage them obviously not to gamble because we wouldn’t be able to enforce that in any way’ (Social Worker 3).

For clients with decision-making capacity, practitioners tended to concentrate on helping them with money management:

‘Nothing can change his (client’s) routine from the betting shop. We have managed to get it under control because we now have control of his money with his agreement without our support he would literally go to the bank and empty his bank account in probably a day’ (Cluster Manager - Supported Living Accommodation).

One practitioner reported having proactively approached betting shop staff in order to obtain support with managing a client's gambling behaviour. Initially, this was forthcoming but the advent of new staff diminished their co-operation:

'I found it really difficult and I know the team found it very difficult. Again because people have capacity to make the right decisions and the wrong decisions...we even went into the betting office....we said, "is there any chance you could relent on this gentleman?"...they were quite helpful actually, they said they would suggest that he only places the minimum bet and that worked for a while until they had new staff and then new staff were younger and refused to entertain that. But some of the older staff, recognised this gentleman was just gambling money that he couldn't afford to gamble and were quite helpful' (Social Worker 6)

Another practitioner had visited a betting shop to discuss the impact of gambling for one of their clients but found the staff's response unhelpful:

'I went in and spoke to the local shop when the £2 machine (slot machine only taking £2 coins) came in and said, look, I've got a bit of a problem, this has become an absolute magnet for one of my service users, I don't know if you know, he is losing a lot of money. Their attitude was, "oh, we cannot tell him not to bet, it's there. You know, that's how we make our income".' (Cluster Manager for Supported Living Accommodation).

Some practitioners described cases where the level of the risk had led to them taking over a client's finances legally to prevent them from experiencing GRH as a consequence of other people's gambling behaviour. For example, when acts of neglect or abuse in relation to gambling were suspected, then practitioners could make a Section 42 enquiry under the Care Act 2014 to help them to decide whether action should be taken and if so, what and by whom. In one case a family carer was suspected of abuse together with acts of neglect by 'walking out and leaving her [client] when he felt stressed and using her bank cards to fund his gambling habit' (Social Worker 7). The enquiry found:

'... sufficient evidence to state that neglect and acts of omission had taken place and financial abuse had occurred...so a safeguarding plan was put in place and part of that safeguarding plan was to protect the (client's) finances and from other abuse' (Social Worker 7).

Practitioners also reported sometimes liaising with a client's family and/or carers in order to address GRH, with varying degrees of success. Some family members felt seemingly powerless or ashamed by their relative's gambling behaviour:

'The family members were equally as frustrated. Some in the past have been quite in denial really, but there are some families I've worked with who did know what was going on, but didn't want to say or anything, they were embarrassed that Dad didn't know better' (Senior Social Worker 3).

Practitioners could also act as a go-between for the client to talk with their family in order to make them aware of the client's gambling and how it could be better managed:

'the family...weren't aware of it, but we needed to get some form of input from them... the care manager was involved too, she brought the conversation round as to how he manages his money... and then it sort of opened up the conversation and he said that he spends most of his money in the gambling shop and he'd rather do that than go to the theatre or go to the cinema... they said, well as long as you agree to be supported to remain within your benefits and so that you can still feed yourself etc., then the surplus money, can be used for gambling.' (Cluster Manager - Supported Living Accommodation)

One practitioner thought that support workers, in greater day-to-day contact with clients, may be better placed to identify GRH and encourage affected individuals to discuss their gambling problems:

'... something like a support worker is probably a really crucial point, potentially. Because if someone's encouraged to talk about it, and if they do have shame about admitting to it, if those barriers can be broken down, those feelings can be talked about and if those feelings can be challenged, the shame can be challenged, that could then lead to the next step.... support workers often can be the first to identify it' (Social Worker 1).

Despite uncertainty, many practitioners had provided support around gambling to clients. This included assisting clients access gambling activities, discussing their gambling behaviour, contacting gambling support services and money advice services on clients' behalf, helping clients with budgeting and money management, liaising with staff in local gambling environments and taking control of their finances (with the client's consent).

In other instances clients were reportedly unwilling to seek help for their gambling problems and practitioners were concerned about whether certain treatment options were appropriate for them:

‘I’ve tried to talk to him about it. He usually changes the subject... it was only really this residential unit that I thought might be an option for him... I mean I know that there’s sort of self-help groups and telephone helplines that he could call but he doesn’t have access to a phone and he doesn’t like talking to people using my phone either’ (Senior Social Worker 1).

Another tactic employed was to try and engage a client in new activities:

‘we tried to steer him to lots of different activities that didn’t involve gambling... we tried to encourage him to meet new people, to try lunch clubs... fishing... to see if we could give him something else that didn’t involve money and was enjoyable’ (Senior Social Worker 3).

Desire for professional development activities

The practitioners reported that they would like professional development activities, training, guidance, policies and procedures to refer to and aid them in their practice when encountering incidences of GRH. This was largely because there was no statutory guidance or specific policies at local authority or individual service level to support them:

‘There’s no specific policy we’ve got, and I don’t think there is a specific policy via the local safeguarding board’ (Practitioner - adult safeguarding)

‘if you think about the Care Act for a moment, I don’t think the word gambling is in the Care Act, to the best of my knowledge, or the statutory guidance...so potentially there is a big gap there...understanding of this aspect has perhaps been overlooked’ (Safeguarding Adults Manager)

- ‘we don’t have a separate policy in relation to gambling’ (Social Worker 3)

Another highlighted that practitioners might need to develop skills in other areas such as numeracy in order to understand the mechanics of gambling and discuss with clients the potential risks. This was mentioned specifically in relation to people who gambled in betting shops who may study the ‘form’ of sports teams, race horses and greyhounds and betting odds, but may not fully understand

what the odds represent in terms of possible winnings or losses before placing a bet and could seek advice from practitioners:

- 'are they capacitated for those decisions to gamble that day, or make that particular bet that would cause them harm if they lose? How might they demonstrate that they understand all the consequences of that? And my sense is that's quite a skilled conversation because one of the things that plays out is gambling involves maths and understanding some of those decisions [...] I think a number of my colleagues said well that's not my strongest area....what did somebody say? "I'm a social worker not a mathematician" and I thought, oh okay, interesting' (Safeguarding Adults Manager)

Training and education about GRH were requested including how to identify clients experiencing GRH and sources of help:

'I think it would help if we had additional training to look for signs, to understand what to do, just for those questions to be answered. What do I look for? Why is it happening? How can I get help? [...] 'Cause I think it is something that staff find a dilemma... it would help you a great deal to know what tools you have at your disposal [...] I would think that definitely local authorities and staff need additional training just to recognise what's going on and how to deal with people' (Senior Social Worker 3)

Many practitioners were unaware of any local services offering gambling support or the details of national gambling support services:

'I'm not aware that there is any local ones, obviously there are local statutory departments to do with alcohol and drug abuse...if we've needed it we've sort of put people in touch with national ones' (Social Worker 3)

'I'm not sure if there's anything local in (my part of the city)' (Social Worker 4)

These comments suggest that practitioners had little knowledge of support services for gambling and this lack of awareness may prevent them from intervening in a helpful way. Similarly, most were unaware of self-exclusion schemes (which enable individuals to bar themselves from gambling environments and online gambling websites for a set period of time) and software which prevents individuals from accessing online gambling websites. Clients could use such schemes and tools to help them to manage their gambling behaviour (see Box 1 for an overview of self-exclusion schemes,

gambling support services and gambling management tools) but few practitioners interviewed would have been able to suggest this as an option.

Equally they were unsure of how responsible gambling was promoted within gambling environments and were largely unaware that gambling operators are obliged to interact with customers where there are concerns that their behaviour may indicate problem gambling (Gambling Commission, 2016: 3.4). Typical responses to questions about practitioners' knowledge about the current practices in gambling environments and responsible gambling initiatives were:

- 'No, I don't know. My guess is, there's a consideration of, does somebody have capacity and people can say that I want you to block me, bar me, I guess that is really down to the gambling company being proactive'. (Senior Social Worker 2).
- Box 1: List of self-exclusion schemes, gambling support services and gambling management tools available in England

Self-exclusion

An initiative which allows individuals to bar themselves from gambling environments and online gambling websites for a set period of time (<http://optintoselfexclude.info/>) .

Amusement arcades:

Bacta

<https://bacta.org.uk/self-exclusion/>

Betting shops:

Multi-operator self-exclusion scheme

<https://self-exclusion.co.uk/>

Bingo halls:

Bingo Association

<http://www.bingo-association.co.uk/site/bing/templates/selfexclusion.aspx?pageid=181&cc=gb>

Casinos:

Playing safe – self-enrolment national self exclusion

<http://www.playingsafe.org.uk/sense-information>

Online gambling websites:

GAMSTOP

<https://www.gamstop.co.uk/>

Gambling support services:**National Gambling Helpline**

Provides confidential advice, information and emotional support throughout Great Britain to anyone experiencing problems with gambling

Freephone: 0808 8020 133 (8am to midnight, seven days a week)

GamCare

Leading provider of information, advice, support and free treatment to anyone affected by problem gambling.

<https://www.gamcare.org.uk/>

GamAnon

Local support groups for anyone affected by someone else's gambling problem

<http://gamanon.org.uk/>

National Problem Gambling Clinic

Delivers care and support who have difficulties that might be described as complex

<https://www.cnwl.nhs.uk/cnwl-national-problem-gambling-clinic/>

Gordon Moody Association

Provides advice, education and therapeutic support to problem gamblers and those affected by problem gambling through residential, online and outreach services.

<https://www.gordonmoody.org.uk/>

Gamblers Anonymous

Offers help to compulsive gamblers

<https://www.gamblersanonymous.org.uk/>

Gambling management tools:

Gamban

Allows individuals to block online gambling websites and apps

<https://gamban.com/>

Monzo bank

Bank which allows its customers to block gambling transactions

<https://monzo.com/blog/2018/05/16/gambling-self-exclusion/>

Starling bank

Bank which allows its customers to block gambling transactions

<https://www.starlingbank.com/blog/merchant-blocking-gambling-betting/>

Discussion

This study explored practitioners' knowledge about GRH experienced by adults with health and social care needs. Practitioners from adult social care, safeguarding, social work and gambling support services drew on their experiences to provide examples from their practice of how GRH can affect clients and how they supported clients experiencing or at risk of GRH.

Participants acknowledged the appeal of gambling and acknowledged that gambling environments could be viewed by clients as comfortable and welcoming. They also recognised the appeal of online and mobile gambling to people with reduced mobility. However, many raised concerns about whether some of their clients fully understand the potential risks, benefits and impact associated with gambling. This was particularly so for clients lacking the necessary cognitive and/or numeracy skills to engage with gambling without problems.

There was evidence that gambling and GRH may be a new or emerging issue for practitioners working within adult social work (in England many addictions services are located in the NHS or in the not-for-profit sector (charities)). Participants had encountered few cases but reported a range of GRHs that some clients had faced. Some were as a result of clients' own gambling participation but also as a consequence of other people's gambling. In relation to the latter, this sometimes led to

victims not wanting to report the alleged crime to the police yet practitioners were tasked with safeguarding clients from further harm and promoting their wellbeing.

In general, participants acknowledged their limited knowledge of gambling and GRH. This was ascribed to the absence of these subjects within education, training, guidance and professional development activities. Most were sometimes unsure how to identify and effectively manage cases of GRH although some reported that it was easier when clients did not have decision-making capacity. Here there were established policies, procedures and legislation to follow which could help safeguard clients from GRH. In cases where clients had capacity, practitioners tended to focus on money management; however, this necessitated spending time on putting budgetary plans into place and monitoring clients' expenditure on gambling.

Participants considered they were well-placed to help support clients experiencing GRH as they thought that they were able to talk with clients about their gambling and encourage help-seeking behaviours. Nonetheless, most were largely unaware of 'responsible' gambling initiatives, gambling management tools and gambling support services, although they saw a generalised need for more training, information and guidance about how to identify, signpost and support clients experiencing GRH. Practitioners were also unsure of the responsibilities of gambling operators and their duty of care in protecting vulnerable adults from GRH. Participants envisaged that partnership working with other services and making links with the gambling industry might be beneficial to their efforts supporting clients experiencing GRH and were amenable to such external input. For example, participants would like someone (unspecified) to have open and honest conversations with the gambling industry about the harms that clients encounter, how to mitigate such harms and contribute to discussions about the design and promotion of responsible gambling initiatives. However, practitioners were also sceptical of whether the industry would be amenable to such involvement if the industry does not put much emphasis on socially responsible practices.

The interviews provided insights into what these largely non-specialist (in terms of gambling) practitioners know about harmful gambling among their clients. However, three limitations should be borne in mind. First, our sample was recruited through snowballing, advertising and contacts. Despite our broad sampling framework only 21 interviews were conducted. Larger samples would help determine if these experiences are generalisable. Second, there is a risk of bias in that participants may have recalled cases that caused them particular concern, only partially recalled cases, recalled exceptional cases or those which occurred some time ago and so may be subject to biases of hindsight. Third, we focused on adult social work and so cases involving families with children were not discussed. Notwithstanding these limitations, this paper presents new and unique

data about reflections on contemporary UK social work in respect of GRH from the frontline of practice.

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